January 26, 2016

The Honorable Orrin Hatch
Chairman, Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
U.S. Senate Committee on Finance
Bipartisan Chronic Care Working Group

The Honorable Mark Warner
U.S. Senate Committee on Finance
Bipartisan Chronic Care Working Group

Re: Bipartisan Chronic Care Working Group Policy Options Document

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

On behalf of the American Academy of Actuaries'[1] Medicare Subcommittee, I appreciate this opportunity to provide input on the Bipartisan Chronic Care Working Group *Policy Options Document*. We support the working group's goals of developing policies to improve care for Medicare beneficiaries with chronic conditions while also reducing the growth in Medicare spending. We concur that achieving these goals requires engaging beneficiaries, encouraging innovation, increasing care coordination, and shifting treatments to lower-cost settings.

Identifying Medicare beneficiaries with chronic conditions. Several options aiming to increase care coordination and improve outcomes among Medicare beneficiaries with chronic conditions would require identifying beneficiaries with chronic care needs. For instance, the option to expand the Independence at Home (IAH) demonstration program nationwide would potentially modify the method of identifying complex chronic care beneficiaries. Currently, eligible IAH beneficiaries are those who have undergone a non-elective hospitalization within twelve months of program participation. A policy under consideration by the committee would instead base eligibility on risk scores from the hierarchical condition categories (HCC) risk adjustment model. Other policy options requiring identification of eligible beneficiaries include establishing a new high-severity chronic care management code, establishing a one-time visit

[1] The American Academy of Actuaries is an 18,500+ member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

code post diagnosis of a serious illness, and allowing Medicare Advantage (MA) plans and accountable care organizations (ACOs) to vary the benefit structure based on chronic conditions.

The eligibility criteria for different approaches likely will vary based on the particular intervention and goals of each approach. A consideration regarding the use of HCC risk scores to identify beneficiaries with chronic conditions is that HCCs are calibrated to reflect health care spending. Individuals with high risk scores are more likely to have high health spending, but not necessarily multiple chronic conditions. Therefore, for the purpose of identifying enrollees with chronic conditions, HCC risk scores would need to be recalibrated and possibly redesigned to expand the extent to which certain combinations of conditions are identified. The presence of a particular number of chronic conditions and/or specific conditions or combinations of conditions could be used instead of or in addition to risk scores to identify eligible beneficiaries. Incorporating prescription drug data into the HCC model could also better identify those with chronic care needs.

Importantly, when setting eligibility criteria, efforts should be made to identify those conditions for which the intervention is known to be effective. Otherwise, resources may be allocated without a likely improvement in outcomes or reduction in spending.

Increasing the services covered by Medicare Advantage plans. Currently, beneficiaries with end stage renal disease (ESRD) are allowed to participate in MA only if they are already enrolled in an MA plan at the time of their ESRD designation. In addition, MA enrollees who opt for hospice care have their Part A and B services paid by the traditional fee-for-service program and the capitated payments to MA plans are commensurately reduced. Proposals to improve care coordination for Medicare beneficiaries would incorporate ESRD and/or hospice benefits directly into the MA program.

A consideration with such proposals is whether all MA plans would be required to incorporate these benefits. If so, network adequacy and other requirements might be needed to ensure that the MA plan can provide the range of services needed for affected beneficiaries.[2] The impact of such requirements on program costs should also be considered. If coverage of these services is not required but instead is voluntary, selection concerns could arise. For instance, plans offering coverage to ESRD beneficiaries would be at greater risk for enrolling beneficiaries with high health care needs. Under either the mandatory or voluntary scenario, it would be necessary to recalibrate the risk adjustment methodology to appropriately compensate MA plans for the risks they bear. In other words, payments to plans for ESRD and hospice enrollees should not be too low, or plans will attempt to avoid these beneficiaries. Likewise, they should not be too high, or windfall profits would accrue to plans and spending for the Medicare program would increase.

Another important consideration relates to how MA benchmarks and bids would need to be adjusted, especially in the case of allowing all ESRD beneficiaries to choose MA plans. Currently, capitated payments to MA plans are determined separately for ESRD and non-ESRD enrollees and the risk adjustment methodology differs between the two populations as well. MA plans do not submit bids for ESRD members, but instead receive payments set directly by the

[2] This already may be an issue for Medicare beneficiaries enrolled in an MA plan who later need dialysis and related treatments.

Center for Medicare and Medicaid Services (CMS). MA plans can adjust their non-ESRD bids to cover any differences between projected ESRD revenue needs and the premiums set by CMS. This structure could continue. However, it would be important to understand how increasing ESRD membership in MA plans could impact the bids and member premiums for non-ESRD beneficiaries.

Alternatively, the groups could be combined, with differences between ESRD and non-ESRD capitated payments being reflected solely through risk adjustment. This could simplify the benchmark and bidding process, but would increase the importance of having an accurate risk adjustment methodology.

Providing additional payments to providers for care coordination activities. Beginning in 2015, a new payment code under the physician fee schedule was implemented for non-face-to-face encounters. The intention is to provide incentives for providers to perform care coordination activities. A proposal under consideration by the committee would expand upon this approach by creating an additional code for high-severity chronic care coordination. However, when these payment codes require beneficiary cost sharing, there may be reluctance among providers to make use of them, especially for beneficiaries without supplemental coverage. Waiving beneficiary cost sharing could increase take up of these activities. When the provider payments are relatively low, it is less necessary to impose reporting or other requirements on providers to certify that care coordination activities are indeed being undertaken. However, as payment levels increase, consideration should be made to impose such requirements.

Allowing more flexibility to MA plans. Chronic condition special needs plans (C-SNPs) target beneficiaries with particular conditions and can structure cost sharing around the designated chronic condition. Several suggested policy changes would grant more flexibility to the broader set of MA plans to meet the needs of beneficiaries with chronic conditions. Increasing flexibility for MA plans could come in the form of allowing benefit structures that vary based on chronic conditions (i.e., a value-based insurance design approach), expanding the range of allowable supplemental benefits, and allowing the inclusion of telehealth in the annual bid amount.

The concept behind these approaches is that they could allow for better targeting of services that are beneficial to those with chronic conditions. In addition, behavioral design principles could improve adherence to evidence-based treatment protocols. Whether such approaches are successful at improving outcomes and reducing costs depends in part on striking the appropriate balance between offering additional benefits (or lower cost sharing) and limiting those benefits to enrollees for whom they would be most effective. If additional benefits are provided to a range of enrollees that is too broad, the costs could outweigh the improvement in patient outcomes. Research that focuses on interventions among the chronically ill could help efforts to better target interventions. Even so, designing benefit structures that vary based on chronic conditions could be difficult to implement in practice.

When allowing flexibility to MA plans, it is also important to ensure that such flexibility does not lead to adverse risk selection issues. MA plans should not be allowed to use benefit design flexibility to attract only lower-cost enrollees or avoid higher-cost enrollees, relative to their risk-adjusted capitated payments. CMS currently prohibits benefit designs that would discriminate

against enrollees with specific or high-cost needs, through for instance disproportionately higher out-of-pocket costs. The risk adjustment system would help avoid incentives to select risks, but additional safeguards might be needed.

Allowing more flexibility to Accountable Care Organizations. Similar to options put forward for increased MA plan flexibility, increasing the flexibility for ACOs could come in the form of allowing the provision of supplemental services and the ability to expand telehealth. Another approach would allow ACOs the choice of prospective or retrospective beneficiary assignment and also would allow beneficiaries to voluntarily elect ACO assignment. These approaches aim to give ACOs additional tools by which to manage their beneficiaries' care. In particular, they can provide increased incentives and opportunities for beneficiaries to receive care within the ACO structure rather than from a non-ACO provider. Assigning beneficiaries prospectively would significantly improve the ability and incentives of ACOs to manage their enrollees' care and allocate their resources more efficiently. Up-to-date provider directories would facilitate beneficiaries obtaining services within the ACO, and would be especially necessary if beneficiaries could voluntarily join an ACO.

As with risk selection concerns related to giving MA plans increased flexibility, if Medicare beneficiaries are allowed to voluntarily elect ACO assignment, it is important that ACOs not be allowed to use benefit flexibility to attract or avoid particular beneficiaries. The risk adjustment system will help avoid such incentives but additional safeguards might be needed.

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We appreciate the opportunity to provide this input and would welcome the opportunity to discuss it with you in more detail. If you have any questions or would like to discuss further, please contact David Linn, the Academy's health policy analyst, at 202-785-6931 or linn@actuary.org.

Sincerely,

Michael J. Thompson, MAAA, FSA
Chairperson, Medicare Subcommittee
American Academy of Actuaries